

Central **LHIN**



Together, we're better

2010/11 Annual Report

Ontario's LHINs: Making a difference



The Central Local Health Integration Network (LHIN) is one of 14 LHINs established by the Government of Ontario in 2006 to plan, coordinate, integrate and fund health services at the local level.

For Ontario's health care system, this means that people are receiving the right care, at the right time, in the right place. This is being achieved through the LHINs by:

- Putting local health dollars where they are most needed, based on community and provincial priorities
- Working with communities to help integrate health services so care is better coordinated and more efficient
- Improving access to quality care for all Ontario residents
- Ensuring that health service providers not only do what is right for their own organization, but also what is right for the system
- Reporting to the Ministry of Health and Long-Term Care through a formal Accountability Agreement, which outlines our responsibilities and performance requirements

LHINs reflect the idea that communities know their own health needs and priorities best. Working together with our health service providers, we are making it easier for people to receive the best possible care, in the most appropriate setting, when they need it. Visit www.lhins.on.ca for more information on how LHINs are making a difference.

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Message from the Chair and CEO



Canada and Ontario provides care to all who come through our doors. It's a basic right for every Canadian citizen, and one that we hold true and dear. As a funder of local health care, however, it is a constant challenge to maximize resources so that we can best meet the needs of the local health care system and provide care to everyone who needs it.

At the Central LHIN, our health service providers, staff and Board of Directors are doing everything we can to ensure that the money we do have is spent where it is needed most. And decisions for that money are made on a system level.

Under the guidance of our Integrated Health Service Plan for 2010-2013 (IHSP), the Central LHIN is continuing to focus on four key planning priorities. These include: Emergency Department and Alternate Level of Care, Chronic Disease Management and Prevention, Mental Health and Addictions, and Health Equity.

In 2010/11, we made significant progress on some of these key areas of focus. Highlights include:

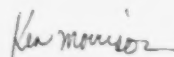
- Investing \$52.9 million through 62 Aging at Home projects to address key LHIN and government priorities, including emergency department and alternate level of care pressures
- Decreasing wait times for all patients who were treated and then discharged from the emergency department despite an increasing number of very sick people visiting the emergency department

- Reducing wait times for cancer surgeries, cardiac by-pass procedures, cataract surgeries and diagnostic MRI and CT scans
- Expanding the Home First Program across the LHIN to relieve alternate level of care pressures in hospitals
- Leading the development of a pan-provincial vision for how LHINs can advance quality improvement in support of the *Excellent Care for All Act, 2010*

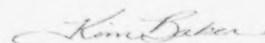
As we look forward, the demands on the health care system in the Central LHIN will continue to increase. Not only is Central LHIN the most populated and one of the fastest growing LHINs in the province, it is also set to experience greater-than-average population aging over the next 10 years. These realities pose significant challenges for our health service providers as they continue to work to meet the ever-increasing demand for high-quality health care and services.

But the good news is this – Central LHIN's health service providers are more thoroughly engaging and consulting our communities, and the people they serve, in important decisions. They are introducing new – and expanding existing – programs and services to better meet the needs of our communities. They are working together to better coordinate the delivery of service to our communities, and leveraging each others' knowledge and experience. And they are seeing positive results through identified efficiencies and process improvements.

Thank you to our health service providers, and to the Central LHIN Board of Directors and staff for their hard work and dedication to advancing quality health care for our communities. Together, we are better.



Ken Morrison
Chairman of the
Board of Directors



Kim Baker
Chief Executive
Officer

Board of Directors

The role of the LHIN Board of Directors is to oversee, advise on and govern the strategic direction and priorities of the LHIN. Members are appointed by an Order-in-Council for a term of one to three years, subject to two terms (up to a six-year maximum). The Board of Directors is accountable, through the Chair, to the Minister of Health and Long-Term Care for the LHIN's use of public funds, and for its results in terms of goals and performance of the local health system.



Kenneth A. Morrison – Chair
June 2, 2005 – June 1, 2011
Newmarket



Eugene Cawthray
May 17, 2006 – June 16, 2010
King City



Arthur W. Walker – FCA, Vice Chair
June 2, 2005 – June 1, 2011
Bradford



John Langs
Sept. 24, 2008 – Sept. 23, 2011
Toronto



Sandy Keshen – Board Secretary
June 2, 2005 – June 1, 2011
Richmond Hill



John Rogers
Mar. 10, 2010 – Mar. 10, 2013
Keswick



Colin Benjamin
Jan. 5, 2006 – Jan. 4, 2011
North York



Elaine Walsh
June 17, 2006 – June 16, 2010
Unionville



Raksha Bhayana
May 17, 2006 – May 16, 2011
Thornhill



Constantine Georganas
June 15, 2010 – March 2011 (deceased)
Richmond Hill



Maneesh Mehta
June 15, 2010 – June 15, 2013
Unionville

Details on the Central LHIN Board of Directors can be found at www.centrallhin.on.ca.

About the Central LHIN

Central LHIN's mandate is to plan, coordinate, integrate and fund health services at the local level. In 2010/11, Central LHIN's budget was \$1.76 billion, which was allocated across a range of health programs through 112 Accountability Agreements with 90 health service providers, including:

- Seven public and three private hospitals
- 46 long-term care homes
- 38 community support service providers
- 21 mental health and addiction service providers
- One community care access centre (CCAC)
- Two community health centres

Demographic trends

Central LHIN's activities and investments are informed by what we know about the people who live in our LHIN and the overall health of our population. Growth, aging and diversity are three key population trends that continue to feature prominently for Central LHIN. One of our key challenges is to meet the increasing demand for care and services as our population continues to grow and age at a rate above the provincial average.

Population aging

Central LHIN will experience greater-than-average population aging over the next 10 years with the 65 and up age category projected to grow from 212,949 to 323,669. That's a 52 per cent increase, which is over 10 per cent greater than the provincial average over the same period.

Diversity

About 48 per cent of Central LHIN's population is comprised of immigrants. This is the highest proportion of immigrants among all the LHINs in Ontario, and 42 per cent of our population identify themselves as visible minorities – at 42 per cent, this is almost twice the provincial average.

Quick facts

- More than 1.7 million residents live within the Central LHIN, which is 13.2% of Ontario's population
- Central LHIN is experiencing a growth rate of 19% over the next 10 years, which equates to an additional 600,000 people by 2020
- Over the next 10 years, Central LHIN is expected to experience an increase of 52% to our senior population
- Central LHIN has the highest proportion of immigrants in Ontario and twice the provincial average of visible minorities



Aboriginals

At just under 0.5 per cent of our population – or 7,000 people – Central LHIN has a relatively small Aboriginal / First Nations population. The majority of this community is located in the northern section of our LHIN on Georgina Island and in South Simcoe County.

Francophones

The definition of "Francophones" is more inclusive than just those individuals whose first language is French. In fact, the term "Francophone" was redefined in 2009 to also include those whose mother tongue is neither French nor English, but who speak French at home or who come from a place where French is an official language. With this in mind, Central LHIN's current proportion of Francophones is approximately 3.2 per cent, or about 56,000 people.

Population

Home to more than 1.7 million residents, Central LHIN is the most populous and one of the fastest growing LHINs in Ontario. Because Central LHIN is one of the smallest LHIN's geographically, our population density is 40 times greater than the provincial average.

Geography

Central LHIN is geographically varied and comprises section of northern Toronto, most of York Region and South Simcoe County. Although the majority of our LHIN is urban with over 70 per cent of the population residing within north Toronto, Vaughan, Richmond Hill and Markham – there is a significantly rural region to the north.

Health profile

Examining our LHIN's health profile helps us work towards our goal of reducing health disparities and enhancing access to care in our LHIN.

Generally, our residents have a lower incidence of chronic diseases and conditions such as high blood pressure, diabetes, heart disease, arthritis and asthma than that of Ontario as a whole.

However, between our planning areas there are variations in health status due to varying levels of education, unemployment and risk behaviours – such as smoking and obesity – which have all been shown to influence an individual's health.

According to the Canadian Institute of Health Research, high-risk populations are groups of people that share characteristics – such as homelessness, single women living in poverty or lone-parent families – associated with a high risk of adverse health outcomes.

Two of our planning areas – South Simcoe / Northern York Region, and North York West – are identified as high-risk from a population health standpoint. A higher number of the residents in these two planning areas face serious chronic diseases, as well as obstacles to accessing primary care, compared to other planning areas in the LHIN.

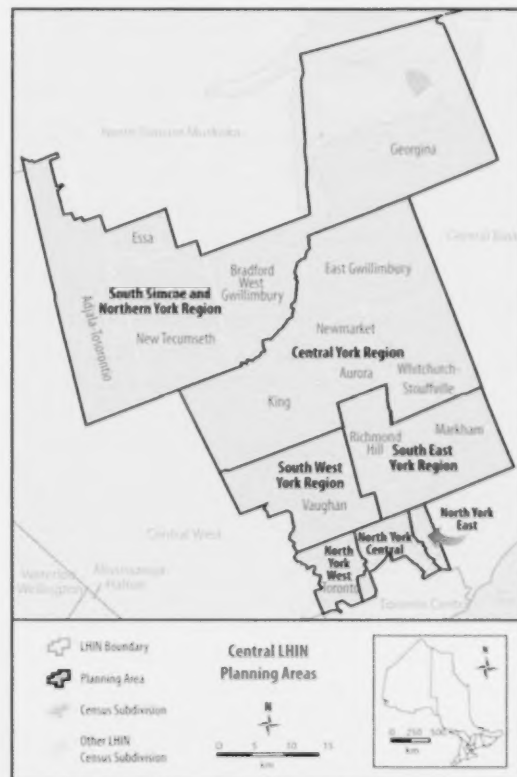
Quick facts

The prevalence of **diabetes** in the Central LHIN is expected to grow 51% (compared to 32% in Ontario) by 2018. This is partially attributable to the fast growing seniors population, projected to increase by 52% by 2020, resulting in increased risk for other conditions. Approximately two-thirds of Central LHIN adults have at least one chronic health condition, and 43% have two or more.

Central LHIN's planning areas

Central LHIN's geography is divided into seven planning areas, as illustrated by the map below. These areas have varying sizes, age structures, economic conditions and social characteristics.

Because Central LHIN's planning areas are so different, each has its own unique challenges and needs that have to be considered when planning at a system level.



Central LHIN population factors by planning areas

Community	Population (2008 data)	Largest municipality (by population)	Profile	
South Simcoe and Northern York Region	113,257	Georgina (York Region)	Immigrant:	14%
			Senior:	11%
			Francophone*:	1%
			Aboriginal:	1.4%
Central York Region	204,207	Newmarket (York Region)	Immigrant:	21%
			Senior:	11%
			Francophone*:	2%
			Aboriginal:	0.8%
South East York Region	465,683	Markham (York Region)	Immigrant:	54%
			Senior:	10%
			Francophone*:	1%
			Aboriginal:	0.4%
South West York Region	230,536	Vaughan (York Region)	Immigrant:	45%
			Senior:	9%
			Francophone*:	1%
			Aboriginal:	0.1%
North York West Region	237,884	North York (Toronto)	Immigrant:	59%
			Senior:	15%
			Francophone*:	1%
			Aboriginal:	0.4%
North York Central Region	276,973	North York (Toronto)	Immigrant:	56%
			Senior:	17%
			Francophone*:	1%
			Aboriginal:	0.2%
North York East Region	123,141	North York (Toronto)	Immigrant:	63%
			Senior:	14%
			Francophone*:	1%
			Aboriginal:	0.2%
Central LHIN (total)	1,651,681	York Region	Immigrant:	48%
			Senior:	13%
			Francophone*:	1%
			Aboriginal:	0.4%
Ontario	12,986,332	Toronto	Immigrant:	23%
			Senior:	14%
			Francophone*:	4%
			Aboriginal:	2%

*In 2009, the term "Francophone" was expanded to include those who speak French at home or who come from a place where French is an official language in addition to those whose mother tongue is French. Under the new definition, Central LHIN's current proportion of Francophones is approximately 3.2 per cent. The data used for this chart was compiled in 2008, before the term was redefined.

Central LHIN's role as a health care funder

Central LHIN is committed to transparent, responsive and accountable health spending. We work with our stakeholders to plan investments that put local health dollars where they are most needed – based on community priorities – to improve the accessibility, coordination, quality and efficiency of our local health system for patients and their families.



Quick facts

- Roughly \$4.6 million dollars are invested in our local health system *every day*.
- Drug benefits, independent health facilities, laboratories, ambulance services, public health and most physician services are funded directly by the province of Ontario.

Health Service Providers funding allocation

In 2010/11, the Central LHIN authorized transfer payments of \$1,760,411,514 (2010 - \$1,671,803,309) to the following sectors, which represents an increase of 5.3 per cent over the previous year:

Sector	2011	2010
Hospitals	\$1,106,535,927	\$1,051,901,703
Long-term Care Homes	\$296,523,547	\$281,643,069
Community Care Access Centre	\$214,073,634	\$203,474,565
Community Support Services	\$69,137,969	\$65,335,469
Community Health Centres	\$7,666,837	\$7,105,587
Community Mental Health & Addictions Agencies	\$66,473,600	\$62,342,916
TOTAL	1,760,411,514	\$1,671,803,309

Cross-LHIN collaboration

Collaboration among neighbouring LHINs helps strengthen available health services and resources to improve efficiencies across LHIN boundaries.

In 2010/11, Central LHIN continued to be part of an inter-LHIN working group. This group remains focused on supporting a seamless provision of services across LHIN boundaries and Ontario to enable patients to receive the care they need regardless of where they live.

Timely and responsive care

Central LHIN residents benefited in the last year from an increase in the number of procedures performed by our health service providers, reductions in wait times and new services designed to ensure patients receive timely and responsive care in the most appropriate setting.

Wait time improvements

- **Diagnostic CT Scan** wait times *decreased* by 31.8%
- **Cancer surgery** wait times *decreased* by 12.8%
- **Cataract Surgery** wait times *decreased* by 12.7%
- **Diagnostic MRI Scan** wait times *decreased* by 6.6%
- **Cardiac By-Pass Procedure** wait times *decreased* by 3.2%

Emergency department performance

- Number of **high acuity admitted patients** treated within 8 hours *improved* by 7.8%
- Number of **non-admitted low acuity patients** treated within 4 hours *improved* by 3%
- Number of **non-admitted high acuity patients** treated within 8 hours *improved* by 3%

Investing in additional procedures

In 2010/11 Central LHIN invested just under \$26 million in one-time incremental funding, enabling our hospitals to perform:

- 21,182 more MRI hours
- 6,611 more CT hours
- 4,998 more cataract surgeries
- 1,214 more joint replacement surgeries
- 591 more general surgeries
- 548 more cancer surgeries
- 317 more cardiac procedures
- 191 more paediatric surgeries

Initiation of new services

In 2010/11, Central LHIN added the following new services in our communities:

- **Twenty-four new convalescent care beds** at Hawthorne Place Care Centre and **15 new Transitional Care Beds for Reactivation and Restoration** at Markham Stouffville Hospital to reduce premature placements in nursing homes by providing specialized preventative and restorative care to at-risk patients.
- **Four new beds** at West Park Healthcare Centre to provide assessment and rehabilitation support for patients who require mechanical ventilation with the goal of moving them to community settings.
- **Expansion of the Home First Program to 130 active clients** to relieve alternate level of care pressures in hospitals. These enhanced community-based services ensure that clients waiting in acute care beds for alternate levels of care can be safely discharged to their home.



Health system accountability

LHINs enhance system accountability for public funds through the development and signing of Accountability Agreements with our health service providers, and through the LHIN's Accountability Agreement with the Ministry of Health and Long-Term Care. These agreements set out funding and performance deliverables for local services that are aligned with LHIN and Ministry of Health and Long-Term Care priorities. Ultimately, these agreements help us to build a better local health care system that emphasizes quality care for patients and their families that's delivered within available resources. They also support system collaboration to enhance stability and accountability in the health system.

In 2010-11, Central LHIN:

- Negotiated and signed a one-year extension to the 2010-11 Hospital Service Accountability Agreements with our seven public and three private hospitals
- Negotiated and signed a three-year Multi-Sector Accountability Agreement expiring March 31, 2014, with our 56 community sector Health Service Providers
- Negotiated and signed a three-year Long-Term Care Home Service Accountability Agreement with 46 Long-Term Care Homes in 2009/10, which took effect as part of 2010/11 fiscal year

LHIN performance and targets as defined by the Province of Ontario

2010/11 Performance Indicators	Starting point	Performance target	Most recent quarter	% from target for most recent quarter*	Annual result
90th Percentile Wait Times for Cancer Surgery	47	47	41	-12.8%	46
90th Percentile Wait Times for Cardiac By-Pass Procedures ¹	63	63	61	-3.2%	64
90th Percentile Wait Times for Cataract Surgery	102	102	89	-12.7%	102
90th Percentile Wait Times for Hip Replacement ²	139	139	150	7.9%	150
90th Percentile Wait Times for Knee Replacement ²	154	154	167	8.4%	162
90th Percentile Wait Times for Diagnostic MRI Scan ³	136	112	127	13.4%	147
90th Percentile Wait Times for Diagnostic CT Scan	44	38	30	-21.1%	37
Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution**** ^{4,5}	15.43%	13.01%	16.59%	27.5%	16.10%
90th Percentile ER Length of Stay for Admitted Patients ⁶	40.60	36.00	49.78	38.3%	44.28
90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients ⁶	8.70	7.90	7.93	0.4%	7.83
90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients ⁷	4.30	4.20	3.97	-5.6%	3.87
Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions**	16.10%	13.60%	16.91%	24.3%	17.96%
Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions**	16.50%	16.50%	22.17%	34.4%	23.00%
Readmission within 30 Days for Selected CMGs**	15.20%	14.40%	15.57%	8.1%	15.19%

* A negative percentage means the LHIN performance improved compared to the last quarter

** FY 2010/11 is based on only 2 quarters of data (Q1-Q2 2010/11) due to availability

*** FY 2010/11 is based on only 3 quarters of data (Q1-Q3 2010/11) due to availability

¹ Only one hospital within Central LHIN receive incremental funding for cardiac by-pass procedures therefore changes in demand and other factors impact performance significantly from quarter to quarter. A higher number of urgent / emergent cardiac cases compared to elective cases were seen in two quarters of 2010/11.

² Demand continues to exceed funded supply. All Central LHIN hospitals completed hip and knee surgeries in excess of funded volumes.

³ Some hospitals were unable to fully utilize additional incremental funding as third quarter reallocation funding flowed late in the fiscal year.

⁴ Central LHIN long-term care homes' outbreaks reduced Central LHIN's ability to access existing beds, resulting in 1,122 equivalent days lost to admission.

⁵ Central LHIN has made significant progress with efforts to improve the Percentage ALC days and to discharge ALC patients in acute care hospitals to more appropriate destinations. Central LHIN hospitals discharged 397 patients who had a long ALC long stay (ALC > 40 days) from April 1, 2010 to December 31, 2010. As well, the Home First program served about 350 clients waiting in acute care beds for alternate levels of care through the provision of enhanced community-based services enabling them to be safely discharged home. [source: Intellihealth, DAD (interim data)].

⁶ Central LHIN had a significant increase in overall emergency department volume, specifically for high acuity patients, which had an impact on emergency department performance. For example, Central LHIN had the third highest increase in ED volume (17,483 visits or 4%) and second highest increased in high acuity patients (22,309 or 7.8%) in the province when compared to the previous year (2009/10). [source: EDRS].

⁷ Central LHIN continued to perform well for the 90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients and was ranked second in the province for 2010/11 despite an overall increase in ED volume.

Meeting our performance goals

Waiting for care when we are ill or need surgery can be frustrating. Lengthy wait times may also negatively affect our overall care experience and health outcomes. That is why wait times remain both a provincial and Central LHIN priority.

Over the 2010/11 fiscal year, we have reduced wait times for cancer surgeries, cardiac by-pass procedures, cataract surgeries and diagnostic MRI and CT scans. Central LHIN wait times also decreased for all patients who were treated and then discharged from the emergency department despite an increasing number of very sick people coming to the emergency department.

Additional funding allocations have enabled our providers to deliver more cataract, cardiac and hip/knee replacement procedures, as well as more cancer, paediatric and general surgeries.

In 2010/11, Central LHIN provided an additional \$7.1 million in incremental funding for more MRI and CT hours, and invested in programs – through Aging at Home – focused on providing interim beds and increasing system capacity to address alternate level of care pressures in our LHIN.

While Central LHIN remains challenged in meeting our wait time targets for hips and knee surgeries, MRI, alternate levels of care, as well as the emergency department wait time targets for patients who need to be admitted to hospital, we are working together with our partners to make improvements.

Central LHIN hospitals continue to make efforts to reduce emergency department wait times for people who need to be admitted to hospital. In the coming year, health service providers will continue to focus on implementing practices that have been shown to improve flow and better address this issue.

For non-admitted patients, however, Central LHIN had the second best results in the province at 3.9 hours for achieving the 90th percentile ER length of stay for non-admitted minor uncomplicated patients.

In 2010/11, major progress was made in discharging patients with very long stays in acute care hospitals. This was achieved through new physical bed capacity created through the home ventilation program, behavioural support unit, transitional care bed program, and community alternatives to long term care such as the Home First program (130 active clients).

Central LHIN remains committed to working with health service providers to find better ways to improve wait times and patient satisfaction.

Non-admitted patients visiting Central LHIN's emergency departments are being seen within 3.9 hours – that's the second fastest result in Ontario.

LHIN initiatives in support of government priorities

Reducing the time people spend waiting in the emergency department for care is a complex issue that is both a provincial and a Central LHIN priority.

Improving access in the emergency department depends in part on a hospital's ability to either admit patients to its acute care beds, to discharge patients to other appropriate care settings or to safely send them home with the assistance of home-based care.

Central LHIN and its health service providers are focused on improving emergency department efficiency and capacity, and reducing the time spent in acute care beds waiting for alternate levels of care.

Enhancing ER capacity

In 2010/11, Central LHIN invested in programs under the Aging at Home strategy, and participated in two Provincial programs designed to help meet the following Provincial targets:

- Seeing and treating lower acuity patients within four hours
- Treating higher-acuity patients (admitted patients) in the emergency department within eight hours
- Treating higher-acuity patients (non admitted) in the emergency department within eight hours

Pay for Results (Year 3)

In 2010/11, Central LHIN was allocated \$6.1 million as part of the Emergency Department Pay for Results one-time fixed funding. In addition, the Ministry of Health and Long-Term Care introduced new incentive variable funding as another component of the Pay for Results Year 3 program. This provided hospitals with the opportunity to receive more funding based on their performance in meeting specific wait time targets.

Pay for Results funding was directed toward initiatives to help reduce emergency department length of stay and to improve patient satisfaction. The Central Community Care Access Centre and all six Central LHIN acute care hospitals participated in the program. Our hospitals include: Humber River Regional Health Centre (Church

and Finch sites), Markham Stouffville Hospital, North York General Hospital, Southlake Regional Health Centre, Stevenson Memorial Hospital, and York Central Hospital.

The focus on the Pay for Results Year 3 program resulted in improvements compared to 2009/10. For example, the rate of improvement of admitted high-acuity patients treated within eight hours was 7.8 per cent, **ranking first in Ontario amongst all 14 LHINs**. This accomplishment was achieved even though Central LHIN had a higher increase than the Ontario average in both ER volumes and high-acuity patients.



Emergency Department Process Improvement Program (ED-PIP Wave 3)

In 2010/11, Central LHIN supported Humber River Regional Hospital (Finch Site), Southlake Regional Health Centre and Stevenson Memorial Hospital in the third phase of this provincial initiative, which was introduced to address the challenges patients face in accessing timely emergency department care. The objectives of this program include:

- Reducing emergency department wait times
- Improving patient satisfaction
- Improving hospital work environment
- Building capacity for continuous quality improvement and sharing of best practices

For all three hospitals, the success of the ED-PIP was demonstrated with improvement achieved on the ED Pay for Results indicators compared to the previous year.

ER diversion for Mental Health & Addictions

In 2010/11, Central LHIN funded an expansion to the Emergency Department Mental Health and Addictions Diversion Program to improve wait times and offer options for preventing emergency department visits. This program was established to seamlessly connect patients with mental health issues, who do not need hospitalization, with the appropriate community-based services.

Expansion of the Emergency Department Diversion Program from North York General Hospital to Humber River Regional Hospital allowed patients across north Toronto to be offered alternate short-term supports. Additionally, the expansion provided increased coverage in the **North York General Hospital** Emergency Department for their existing program.



Reducing alternate level of care

When patients no longer need acute care in our hospitals, they often remain in acute care beds while they wait to be discharged or transferred. They need an "alternate level of care" such as long-term care, home care or rehabilitation. This often leads to longer wait times in the emergency department as patients wait to be admitted to a bed in the hospital. In 2010/11, Central LHIN continued to work with our health service providers and the Ministry of Health and Long-Term Care to build capacity in our local health system to ensure that people get the care they need: in a hospital, in a rehabilitation or long-term care setting, in the community, or at home.

Central LHIN enhancements made in the past year to improve the alternate level of care situation:

- **Home First expansion with the Central Community Care Access Centre (CCAC)**
 The Home First program was expanded in 2010/11. The purpose of the program – which served about 350 clients in the 2010/11 fiscal year – is to provide enhanced community-based services so clients waiting in acute care beds for alternate levels of care can be safely discharged to their home.

Home First services include assessments, care coordination, nursing, social work, occupational therapy, physiotherapy, personal support services and nutrition.
- **24 new convalescent care beds at Hawthorne Place Care Centre and 15 new transitional care beds at Markham Stouffville Hospital for reactivation and restoration**
 Central LHIN funded these new beds to reduce premature placements in nursing home by providing specialized preventive and restorative care to at-risk patients.
- **4 new beds at West Park Healthcare Centre**
 to provide assessment and rehabilitation support for patients who require mechanical ventilation.

Integrated Health Service Plan (IHSP) priorities

In 2010/11, Central LHIN continued to direct available resources towards making progress in the priorities identified in our IHSP 2010-13. As defined in the plan, Central LHIN's key areas of focus are:

1. Emergency Department / Alternate Level of Care
2. Chronic Disease Management and Prevention
3. Mental Health and Addictions
4. Health Equity



Emergency Department / Alternate Level of Care

In 2010/11, Central LHIN continued to develop a more sustainable health system for seniors by:

- Supporting Provincial priorities to reduce emergency department wait times and alternate level of care pressures
- Leveraging Aging at Home to support IHSP priorities
- Building service capacity
- Addressing gaps in seniors care
- Strengthening linkages between our health service providers and community leaders outside the traditional health sector
- Supporting disadvantaged and underserved groups
- Targeting opportunities that support our Accountability Agreement indicators and Ministry priorities

Aging at Home

In 2011/10, Central LHIN invested \$52.9 million through 62 Aging at Home projects to address key LHIN and government priorities, including emergency department and alternate level of care pressures, and to continue key community-based services.

Highlights include:

- Created 24 new **convalescent care beds**, 15 new transitional care beds, 4 new beds for patients requiring mechanical ventilation and the continuation of 8-bed Behavioural Support Unit, which brings the total capacity through Aging at Home to 145 beds
- Expanded **mental health and addictions emergency diversion** program
- Expanded in-home **palliative care** education and assessment program
- Expanded the **Home First Program** to 130 Active Clients
- Developed a **Falls Prevention program** with St. John's Rehab Hospital for seniors who are at risk of falling. The program helps to: reduce unintentional falls, avoid the physical and emotional impact associated with a fall, and enhance the efficiency of the health care system by reducing the demand on the emergency department and long-term care
- Increased **community support sector capacity**, resulting in:
 - 36,519 one-way transportation rides
 - 29,364 meals
 - 39,021 respite hours

In total, Central LHIN received and distributed approximately **\$100 million from the Provincial Aging at Home program over the last three years**. This includes a \$52.9 million investment* in 2010/11, a \$33.6 million investment* in 2009/10 and a \$13.5 million investment* in 2008/09

* Base increases to the system.

Chronic disease management & prevention

Treatment for diabetes and related conditions – including heart disease, stroke, kidney disease and other chronic conditions – places significant demands on our acute care system and community-based services. It is also very costly.



Unfortunately, chronic disease is on the rise in Central LHIN, and the prevalence of diabetes is expected to grow 51 per cent (compared to 32 per cent in Ontario) by 2018. Approximately two-thirds of Central LHIN adults have a chronic condition, and 43 per cent have two or more.

Central LHIN is committed to improving access to diabetes and renal care by supporting the implementation of the Ontario Diabetes Strategy and the Ontario Renal Network, streamlining the delivery system and putting a plan in place to support self-management.

2010/11 successes in this area include:

- Establishing the **Central Diabetes Regional Coordination Centre** to use local resources and existing expertise to develop and maintain an integrated, coordinated system for the prevention and management of diabetes.
- Investing in education and training for people with diabetes and their health care providers through the Ontario Diabetes Strategy Self-Management Initiatives in Central LHIN.
- Expanding services to five diabetes education programs.
- Establishing the Central LHIN Regional Renal Program to plan, coordinate and support quality improvement for the delivery of renal services across our LHIN.

Mental health & addictions

Linking people with mental illness and addictions to the supports they need is an ongoing challenge. In Central LHIN, we are focusing resources where they make the greatest impact – coordinating care, bridging gaps in the system, reducing wait times for assessment and services, and enhancing community supports.



2010/11 successes in this area include:

- Expanding the North York General Hospital Emergency Department Diversion Program to Humber River Regional Hospital. This initiative focuses on improving the coordination of care delivery between acute care and community-based supports for mental health clients.
- Increasing the number of supportive housing units under the Supportive Housing for People with Problematic Substance Use Program.
- Continuing the Centralized Access Program – through York Support Services Network and Toronto North Support Services – to provide the coordination of and access to case management services, information and service navigation, peer support, eligibility assessments, and individualized short-term support.
- Supporting the Anti-Stigma Project – an education workshop project that was featured by the Mental Health Commission of Canada as part of its new 10-year anti-stigma / anti-discrimination initiative, *Opening Minds*. This project is being replicated in other health regions across the country.

Supporting neurological services

People with neurological-related conditions – such as stroke, acquired brain injury or Alzheimer's disease – require timely access to appropriate care and services. We have focused Aging at Home investments and other resources towards this goal. 2010/11 successes in this area include:

- **The Specialized Residential Home for Hard to Serve Project.** An eight-bed behavioural support unit at Cummer Lodge to increase the ability of the long-term care sector to admit residents with unstable and unpredictable behaviours to a specialty unit for behaviour support
- **Stepping Stone and Community Reintegration Program.** Building on the success of the Crosslinks Seniors program, LOFT Community Services provided assessment and support for seniors with mental illness and addictions living in Homes for Special Care in York Region
- **Expanding services for people with acquired brain injury.** This includes an ABI satellite day program enhancement and a system navigator
- **Bringing the D.A.Y. Centre to Parkview Village in Stouffville** (The Alzheimer Society of York Region). This project delivers a two-day per week cognitively impaired respite program in the Stouffville area. Additionally, the D.A.Y. Centre provides a structured, individualized recreational social day care program for seniors with dementia.
- **Central LHIN Jewish Adult Day Program for Seniors with Dementia** (Baycrest Centre for Geriatric Care). Providing Day Centres for seniors who are living in the community has been identified as a key program for supporting the Aging at Home Strategy, and is believed to help sustain seniors within the community. The Jewish Adult Day Program for Seniors with Dementia project offers expert, professional registered nursing services to clients attending the program. It also provides education and consultation for staff and families.

Health equity

Central LHIN's health equity priority aims to reduce avoidable health disparities within certain population groups in key planning areas.

In addition, the IHSP recognizes that social determinants of health, such as unemployment, education, and access to social capital have been shown to affect people's health and well being, and as such, comprise an important part of the health equity strategy.

The Central LHIN Health Equity priority includes the objective of collaborative planning with ministries such as the Ministry of Community and Social Services and the Ministry of Child and Youth Services. Over the past year, key successes have been achieved in support of the health equity priority. These included:

- Announcement of three new **Family Health Teams** (Don Mills, Humber River Regional Hospital and Woodbridge Medical Centre) and **two Nurse-Practitioner Led Clinics** (Sutton and North York West)
- Ongoing engagement of the **Chippewas of Georgina Island First Nation**
- Establishment of an interdisciplinary **Primary Care Action Group** to enhance primary care integration and engagement in Central LHIN
- Production of a framework and first set of health service provider **health equity reports**

Central LHIN's Health Equity Goals

- **Targeting investments** in health services in identified geographic areas to **address health service inequities**, and improving access to diabetes care and primary care in these areas
- **Engaging the public** and improving collaboration across sectors
- Identifying and supporting **Aboriginal engagement** strategy
- Supporting **French Language Services engagement** strategy
- Monitoring the **health status indicators** in the identified geographic areas

Service integration

Central LHIN is making progress to improve the sustainability of the health system by encouraging integrated service delivery and care models across sectors. Integrated models provide coordinated, accessible and high-quality health care that improves patient care, and makes service delivery more efficient. Examples of local progress in 2010/11 towards this goal in our LHIN include:

Integration Name	Description/Partners	Integration Type	Central LHIN Planning Area
Stevenson Memorial Hospital and Matthews House Hospice	Transfer of hospice services and funding from Alliance Hospice to Stevenson Memorial Hospital in respect of hospice services delivered by Matthews House Hospice	Voluntary	South Simcoe, Northern York Region and Central York Region
Alliance Hospice and Better Living Health and Community Services	Transfer of programs and funding for hospice and caregiver support services from Alliance Hospice to Better Living Health and Community Services	Voluntary	North York Central and North York West
York West Active Living Centre and St. Clair West Services for Seniors	Transfer of programs and funding for congregate dining, transportation and foot care services from York West Active Living Centre to St. Clair West Services for Seniors	Voluntary	Central York Region, South Simcoe and Northern York Region

Central LHIN also regularly monitors outcomes and the status of all health system integrations undertaken per the *Local Health System Integration Act, 2006* by requiring health service providers to report on their post integration activities.

For example, health service providers are requested to provide both qualitative results on progress to date as well as a quantitative analysis based on available data and any efficiency gains achieved. The Central LHIN integration assessment framework dimensions, including access, coordination, quality and efficiency form the basis for this analysis.

Key focus areas for enhancing integration for 2010/11 in the community support services sector:

- Increase administrative efficiencies in the sector
- Leverage the Ministry of Health and Long-Term Care (MOHLTC) funded Community Care Information Management System (CCIM)
- Enhance capacity for front line services through resource optimization

Central LHIN supported the **Community Care Information Management (CCIM) project**, which is implementing standardized client assessment tools in the community support (CSS) and community mental health (CMH) sectors, to improve quality and standardization. To date, 24 CSS and 12 CMH agencies have participated in CCIM's client assessment projects.

Central LHIN funded **Etobicoke Service for Seniors (ESS) to improve coordination and collaboration** in partnership with eight other transportation service providers in Central LHIN. The project completed a comprehensive data analysis which led to a better understanding of the challenges and opportunities. Standard operating terms were also developed consistent with best practices. The project also strengthened collaboration among the Central LHIN HSPs and encompassed productive engagement with Toronto Central LHIN agencies. The project identified opportunities for further collaboration in the areas of shared purchasing, ongoing evaluation, ongoing collaboration and additional best practice development.

Central LHIN funded **Rehabilitation Foundation for the Disabled** (also known as "Ontario March of Dimes") to explore shared services for human resources and purchasing. The project involved collaboration amongst community sector health service providers to examine options for a shared HR service model. It also involved the completion of a business case to reduce back office costs with efficiencies and savings gained from economies of scale, collective buying power, improved service quality and utilization of expertise and knowledge across the sector.

For more on integration in Central LHIN, including *Guidelines for Identifying Integration Proposals*, visit the integration section of our website at www.centrallhin.on.ca.

Community engagement

Section 16 (1) of the *Local Health System Integration Act, 2006 (LHSLA)* states that **"LHINs shall engage the community of diverse persons and entities involved with the local health system about that system on an ongoing basis including about the integrated health service plan and while setting priorities."**

Central LHIN is committed to achieving our vision of Caring Communities, Healthier People, where each of us – from our staff and Board of Directors to our health service providers and our residents – view ourselves as important contributors in working together to create a common vision for the health care system.

Community engagement is a key vehicle through which we will deliver on this commitment. In 2010/11, Central LHIN identified a four-pronged strategy for community engagement, which aligned, enabled and supported the implementation of key goals identified in the 2010-2011 Annual Business Plan.



The **Community Engagement (CE) Guidelines and Toolkit** were implemented by all LHINs in February 2011 to promote standardization and best practices, and improve accountability. They outline requirements for an external review committee, an annual engagement plan, and for including results in each LHIN's Annual Report. The annual community engagement plans provide the public with information on upcoming engagement activities and goals, and how the community can expect to participate. Visit the engaging our communities section of our website at www.centrallhin.on.ca to view the plan.

Key engagement activities

IHSP launch series: Central LHIN initiated five community engagement sessions, including one involving health system users/consumers, across our seven planning areas to launch the Integrated Health Service Plan 2010-2013. More than 175 participants from across the health sectors attended the sessions, which featured presentations by Central LHIN staff, health service providers and an interactive workshop. A number of key themes emerged, including:

- Improving patient education and awareness of the health system in order to enhance navigation of care/services and address appropriate utilization of services. System navigation was seen as particularly challenging for newcomers.
- Enabling greater partnerships and collaboration between community agencies, community mental health providers, hospitals and primary care providers to enable more "integrated care."

- Increasing the focus on community and home care alternatives for patients waiting for long-term care or who have Alternative Level of Care status in hospital.
- Enhancing the role of primary care in supporting system improvement and integration.

Participant feedback was positive and the input on a range of health system challenges and opportunities was integrated into our planning activities for 2011/12.

Primary Care engagement:

Central LHIN is home to two Nurse Practitioner Led Clinics, 11 Family Health Teams, two Community Health Centres, and over 1380 family physicians. Primary care is a key resource through which patients access the health system, and as such, an important enabler across all Central LHIN priorities.

In late 2010, a Primary Care Action Group (PCAG) was established to help advance primary care engagement in Central LHIN. Through this group, Central LHIN supports opportunities that facilitate collaboration between sectors and enhance system integration and patient navigation of the system.

Through efforts of the interdisciplinary PCAG, Central LHIN hosted two successful engagement sessions: **Building Capacity for Diabetes Management in Primary Care** and **Collaboration in Primary Care for Georgina Island Residents**. These sessions featured the combined participation of nearly 100 consumer and health service providers from across Central LHIN.

Themes and recommendations obtained from a summary of the group discussions included a focus on:

- Engaging family physicians in the discharge planning of patients as they transition out of the hospital and into the community
- Improving access to primary care services on and off-reserve for Georgina Island residents, including opportunities to address issues specifically related to transportation and on-island medical services

- Improving communication and dissemination of discharge plans between the hospital and family
- Enhancing family physician access to diabetes management tools and resources
- Enhancing access to diabetes self-management tools and substance misuse aftercare programs

Reports from the engagement sessions were shared with all participants and the Central LHIN Advisory Networks where the recommendations and themes will be considered and integrated into the work plans of these groups for 2011/12.

Collaborating with the Aboriginal community:

Central LHIN's Aboriginal community is a focus of targeted investments and activities under our Aging at Home strategy and the health equity priority of the ISHP. In addition to the Collaboration in Primary Care for Georgina Island Residents community engagement session, Central LHIN meets regularly with the leadership of the Chippewas of Georgina Island First Nation in order to help address issues as they arise.

With respect to the more urban Aboriginal population, Central LHIN participates in a Greater Toronto Area Collaborative, which seeks to:

- Share knowledge, exchange best practices, and learn new approaches to engage health service providers and Aboriginal organizations to address health issues affecting Aboriginal communities in the GTA
- Explore ways to improve access to care, integrate across the continuum, and collaborate across the five GTA LHINs

Engaging the Francophone community:

About 56,000 people – or 3.2 % of Central LHIN's population – identify themselves as Francophone. In 2010/11, the new French Language Planning Entity (Entité de planification pour les services de santé en français #4 Centre Sud-Ouest) was established.

Central LHIN, in close partnership with the Central East and North Simcoe Muskoka LHINs, began to establish a productive working relationship with the Entité, and identified key roles and responsibilities with respect to engaging the Francophone community.

In addition to our collaboration with the Entité, we continued to identify French language engagement opportunities in association with other LHINs, with a particular focus on the Greater Toronto Area, to improve relationships and collaboration across sectors for French speaking members of our community.

In recognition of the importance of access to information in French, as aligned with the Communications in French Directive, we continue to work to improve the accessibility of information – in particular on our website – through the translation of key materials.



Leading community engagement best

practices: On February 15, 2011, all LHINs implemented new provincial guidelines for community engagement. Because health service providers also have an obligation to engage their communities, and given the new provincial community engagement guidelines, Central LHIN established a multi-sector Community Engagement Task Group to facilitate the adoption of the guidelines and advance engagement best practices.

A key component of the Task Group mandate is to develop principles to guide the utilization of the new community engagement guidelines by health service providers as part of their community engagement planning activities in the next year.

Enhancing cross-Ministry / LHIN engagement:

Working across LHINs, local governments and with other Ministries is an important part of the LHIN mandate to engage in continuous planning for a more integrated and high-quality health care system that focuses on the needs of the patient and client or resident, regardless of where they live or where their care needs are addressed in the continuum. Central LHIN supports this ideal through its IHSP and will be working to enhance opportunities to collaborate in this area.

In November 2010, Central LHIN hosted an initial engagement session with health service providers and stakeholders to discuss system opportunities and challenges in providing care to young adults with complex care needs and identify opportunities for partnership/collaboration across sectors. The results led to the establishment of new, positive working relationships as well as including a plan to convene additional engagements in 2011/12.

Engaging local governments: In addition to connecting on an as-needed basis with our MPPs and municipal governments to answer constituency questions and to share information, Central LHIN hosted both our annual MPP breakfast and our annual Municipal Forum.

These sessions gave Central LHIN's leadership team and Board of Directors the opportunity to meet with local government representatives to update them on our activities and priorities, build stronger relationships and continue our ongoing dialogue on local health issues and our shared commitment to improving the health system for the residents of our LHIN.



Building local governance: Central LHIN recognizes the importance of good governance as a fundamental requirement for organizations as they operate in the complex health care environment.

We are committed to promoting and supporting health service provider boards to share best practices and learn from one another.

In 2010/11, Central LHIN four Governance Council meetings at various locations throughout the LHIN, geared to developing governance-level relationships between our board and the chairs of our health service provider boards.

These sessions help to keep Health Service Provider Board Chairs apprised of Central LHIN's actions and investments, and enable participants to discuss governance-level priorities and opportunities for collaboration.

Advancing health system quality

In late 2010, Central LHIN began implementing a strategic approach to advance quality across the care continuum, which included key engagement activities:

- Assumed a leadership role in developing a pan-provincial vision for how LHINs can advance quality improvement (including working with our 46 long-term care homes through the Ontario Health Quality Council's *Residents First* project) and led work with other LHINs to define a strategic role for LHINs to support the *Excellent Care for All Act, 2010*
- Facilitated ongoing quality improvement knowledge transfer across the local health system through a full-day quality symposium
- Conducted a multi-sector environmental scan of quality improvement initiatives including health service provider Quality Improvement Plans
- Supported health service provider capacity development by hosting quality engagement sessions

Close to 300 participants from across the continuum of care, including the governance level, attended **Patients First: Creating Quality in the Transitions of Care** held in March 2011, which highlighted the importance of care transitions in achieving high-quality care and identified the key elements of quality improvement across care settings.

The findings from the symposium will inform Central LHIN's Quality Action Plan for 2011/12, which is expected to include several substantial follow-up engagement sessions.

Financial statements of

**Central Local Health
Integration Network**

March 31, 2011

Central Local Health Integration Network

March 31, 2011

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Independent Auditor's Report

To the Members of the Board of Directors of the
Central Local Health Integration Network

We have audited the accompanying financial statements of the Central Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2011, and the statements of operations, change in net debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of the LHIN as at March 31, 2011, and the results of its operations, change in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

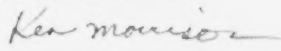
Chartered Accountants
Licensed Public Accountants
May 30, 2011

Central Local Health Integration Network

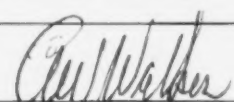
Statement of financial position
as at March 31, 2011

	2011	2010
	\$	\$
Financial assets		
Cash	774,718	659,837
Due from Ministry of Health and Long-Term Care ("MOHLTC")	5,048,235	3,103,069
Due from LHIN Shared Services Office (Note 4)	-	3,643
Accounts receivable	25,974	66,633
	<u>5,848,927</u>	<u>3,833,182</u>
Liabilities		
Accounts payable and accrued liabilities	490,967	679,922
Due to Health Service Providers ("HSPs")	5,048,235	3,103,069
Due to Ministry of Health and Long-Term Care ("MOHLTC") (Note 3)	349,029	381
Due to the LHIN Shared Services Office (Note 4)	2,152	-
Deferred revenue	-	54,042
Deferred capital contributions (Note 5)	203,312	205,188
	<u>6,093,695</u>	<u>4,042,602</u>
Commitments (Note 6)		
Net debt	(244,768)	(209,420)
Non-financial assets		
Prepaid Expenses	41,456	4,232
Capital assets (Note 7)	203,312	205,188
	<u>244,768</u>	<u>209,420</u>
Accumulated surplus	-	-

Approved by the Board



Director



Director

Central Local Health Integration Network

Statement of operations
year ended March 31, 2011

		2011	2010
	Budget (unaudited) (Note 8)	Actual	Actual
	\$	\$	\$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	1,663,394,018	1,760,411,514	1,671,803,309
Operations of LHIN	4,344,422	4,288,477	4,270,119
Emergency Room/Alternative Level of Care ("ER - ALC") Funding (Note 10a)	100,000	100,000	100,000
Aging at Home Funding (Note 10b)	-	-	300,000
Aboriginal Initiative (Note 10c)	10,000	127	30,000
Vaughan Hospital Study (Note 10d)	-	-	215,000
Emergency Department Lead (Note 10e)	75,000	54,000	75,000
Diabetes Strategy (Note 10f)	-	-	25,000
French Language Services (Note 10g)	54,042	40,631	11,958
French Language Health Services (Note 10h)	-	18,459	-
Critical Care Lead (Note 10i)	-	72,750	-
E-Health Ontario funding (Note 10j)	600,000	294,090	600,000
Amortization of deferred capital contributions (Note 5)	231,116	123,021	194,528
	1,668,808,598	1,765,403,069	1,677,624,914
Expenses			
Transfer payments to HSPs (Note 9)	1,663,394,018	1,760,411,514	1,671,803,309
Operations			
General and administrative (Note 11)	4,344,422	4,288,477	4,270,119
ER - ALC funding (Note 10a)	100,000	100,000	100,000
Aging at Home Funding (Note 10b)	-	-	300,000
Aboriginal Initiative (Note 10c)	10,000	127	30,000
Vaughan Hospital Study (Note 10d)	-	-	215,000
Emergency Department Lead (Note 10e)	75,000	54,000	75,000
Diabetes Strategy (Note 10f)	-	-	25,000
French Language Services (Note 10g)	54,042	40,631	11,958
French Language Health Services (Note 10h)	-	18,459	-
Critical Care Lead (Note 10i)	-	72,750	-
E-Health (Note 10j)	600,000	294,090	600,000
Amortization of capital assets	231,116	123,021	194,528
	1,668,808,598	1,765,403,069	1,677,624,914
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

Central Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2011

	Budget (unaudited) (Note 8)	2011 \$	2010 \$
Annual surplus			-
Acquisition of capital assets	85,000	121,145	73,922
Amortization of capital assets	(231,116)	(123,021)	(194,527)
Change in other non-financial assets	-	37,224	4,232
Decrease in net debt	(146,116)	35,348	(116,373)
Opening net debt	209,420	209,420	325,793
Closing net debt	63,304	244,768	209,420

Central Local Health Integration Network

Statement of cash flows

year ended March 31, 2011

	2011	2010
	\$	\$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	(123,021)	(194,527)
Amortization of deferred capital contributions (Note 5)	123,021	194,527
	-	-
Changes in non-cash operating items		
Increase (Decrease) in due from MOHLTC	(1,945,166)	2,878,050
Decrease in accounts receivable	40,659	31,837
(Decrease) in accounts payable and accrued liabilities	(188,955)	(3,132)
Increase in due to the MOHLTC	348,648	381
Increase (Decrease) in due to HSPs	1,945,166	(2,878,050)
Increase in due to the LHIN Shared Services Office	2,152	(24,792)
Decrease in due from LHIN Shared Services Office	3,643	-
(Decrease) Increase in deferred revenue	(54,042)	54,042
(Increase) in prepaid expenses	(37,224)	(4,232)
	114,881	54,104
Capital transactions		
Acquisition of capital assets	(121,145)	(73,922)
Financing transactions		
Deferred capital contributions received (Note 5)	121,145	73,922
Net increase in cash	114,881	54,104
Cash, beginning of year	659,837	605,733
Cash, end of year	774,718	659,837

Central Local Health Integration Network

Notes to the financial statements

March 31, 2011

1. Description of business

The Central Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the Central Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed Health Service Providers have flowed through the LHIN's financial statements. Throughout the years, funding payments authorized by the LHIN to Health Service Providers, are recorded in the LHIN's Financial Statements as revenue from the MOHLTC and as transfer payment expenses to Health Service Providers.

The mandate of the LHIN is to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers most of North York, York Region and South Simcoe. The LHIN enters into service accountability agreements with health service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues and expenses in the fiscal year that the events giving rise to the revenues or expenses occur, and the revenues and expenses are earned or incurred and measurable. Through the accrual basis of accounting expenses include non-cash items, such as the amortization of capital assets and losses in the value of assets.

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budgetary arrangements established by the MOHLTC. The Financial Statements reflect funding arrangements approved by the MOHLTC. The LHIN cannot authorize payments in excess of the budgetary allocation set by the MOHLTC. Due to the nature of the MLAA, the LHIN is economically dependent on the MOHLTC.

Effective April 1, 2007, the LHIN assumed responsibility to authorize transfer payments to Health Service Providers. The transfer payment amounts are based on the terms of the Health Service Provider Accountability Agreements with the LHIN, including any amendments made throughout the year. During the year, the LHIN authorizes the transfer of cash to the Health Service Providers. The cash associated with the transfer payment flows directly from the MOHLTC and does not flow through the LHIN bank account.

The LHIN Financial Statements do not include any MOHLTC managed programs, under which the Health Service Provider is directly accountable to the MOHLTC.

Central Local Health Integration Network

Notes to the financial statements

March 31, 2011

2. Significant accounting policies (continued)

Government transfers

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the transfer is authorized and all eligibility criteria have been met, except when and to the extent that the transfer gives rise to an obligation and a liability is recorded.

Transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work.

Deferred capital contributions

Amounts received that are used to fund capital asset purchases are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset. The amount recorded as revenue in the Statement of Financial Activities is consistent with the amortization expense of the related capital asset.

Capital assets

Capital assets are recorded at cost. Cost includes the purchase price of the asset and other acquisition costs such as design, construction, and duties. Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment and development	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office furniture and fixtures	5 years straight-line method

Use of estimates

The preparation of Financial Statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the Financial Statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently disclose information of all appropriate segments and, therefore, no additional disclosure is required.

Central Local Health Integration Network

Notes to the financial statements

March 31, 2011

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Revenue has only been recognized to the extent that eligible expenditures have been incurred. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

Funding repayable to the MOHLTC is as follows:

			2011	2010
	Funding received	Revenue recognized	Repayable	Repayable
	\$	\$	\$	\$
Transfer payments to HSPs	1,760,411,514	1,760,411,514	-	-
LHIN operations	4,411,498	4,411,498	-	1,977
Special Program Funding	929,086	580,057	349,029	(1,596)
	1,765,752,098	1,765,403,069	349,029	381

4. Related party transactions

In accordance with the Memorandum of Understanding between the MOHLTC and the LHIN, LHINs are required to centrally source and share services for Legal Services, Audit Services, HR Services, IM & IT Infrastructure Development and Management and Management of Recorded Information. The LHINs accordingly formed the LHIN Shared Services Office ("LSSO") as a division of the Toronto Central LHIN. The cost of providing these services is allocated and charged to the LHINs. Any portion of the LSSO operating costs overpaid (or under paid) by the LHIN at year end is recorded as a receivable (payable) from (to) the LSSO.

The LHIN Collaborative (LHINC) was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The cost of providing these services is allocated and charged to the LHINs. Any portion of the LHINC operating costs overpaid (or under paid) by the LHINs at year end, is recorded as a receivable (payable) from (to) the LHINC.

During the year, the LHIN made payments to LSSO and LHINC of \$409,523 (2010 - \$375,000).

5. Deferred capital contributions

	2011	2010
	\$	\$
Balance, beginning of year	205,188	325,793
Capital contributions received during the year	121,145	73,922
Amortization for the year	(123,021)	(194,527)
Balance, end of year	203,312	205,188

Central Local Health Integration Network

Notes to the financial statements

March 31, 2011

6. Commitments

The LHIN has commitments under various operating leases as follows:

	Office space	Equipment	Total
	\$	\$	\$
2012	163,569	7,633	171,202
2013	244,135	7,633	251,768
2014	260,891	7,633	268,524
2015	277,983	-	277,983
2016 & After	320,137	-	320,137

The LHIN enters into accountability agreements with Health Service Providers which include planned funding targets. The actual funding provided by the LHIN is contingent on the MOHLTC providing the funding.

7. Capital assets

			2011	2010
	Cost	Accumulated amortization	Net book value	Net book value
	\$	\$	\$	\$
Office furniture and fixtures	323,386	224,398	98,988	78,744
Computer equipment	124,229	69,655	54,574	61,261
Leasehold improvements	556,518	506,768	49,750	65,183
	1,004,133	800,821	203,312	205,188

8. Budget figures

Budget amounts have been reported in the Statement of Financial Operations to comply with PSAB reporting requirements and reflect the initial budget at April 1, 2010. The budgets were approved by the Government of Ontario.

	\$
LHIN total budget	1,668,808,598
Less Health Service Provider Budget (a)	(1,663,394,018)
LHIN Operating Budget (b)	5,414,580

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Notes to the financial statements

March 31, 2011

8. Budget figures (continued)

a) Health Service Provider Budget

	\$
Initial HSP Budget	1,663,394,018
Adjustments due to announcements made during the year	97,017,496
	<u>1,760,411,514</u>

The total budget by sector is as follows:

Hospitals	1,106,535,927
Long Term Care Homes	296,523,547
Community Care Access Centres	214,073,634
Community Support Services	69,137,969
Community Health Centres	7,666,837
Community Mental Health & Addictions	66,473,600
Total budget	<u>1,760,411,514</u>

b) LHIN Operating Budget

	\$
Initial budget as reported on the Statement of Operations	5,414,580
Additional funding received in-year:	
Funding for capital asset purchased transferred to deferred capital contributions	(85,000)
Closing budget	<u>5,329,580</u>

9. Transfer payments to Health Service Providers

The LHIN authorized transfer payments of \$1,760,411,514 (2010 - \$1,671,803,309) to the following sectors:

	2011 \$	2010 \$
Hospitals	1,106,535,927	1,051,901,703
Long Term Care Homes	296,523,547	281,643,069
Community Care Access Centres	214,073,634	203,474,565
Community Support Services	69,137,969	65,335,469
Community Health Centres	7,666,837	7,105,587
Community Mental Health & Addictions	66,473,600	62,342,916
	<u>1,760,411,514</u>	<u>1,671,803,309</u>

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Notes to the financial statements

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10. a) Emergency Response - Alternate Level of Care (ER-ALC)

The LHIN received funding of \$100,000 (2010 - \$100,000) for the Emergency Response – Alternate Level of Care project. The following are the expense details:

	2011	2010
	\$	\$
Salaries and benefits	97,646	85,431
Accommodation and administration	895	11,005
Supplies and other	1,459	3,564
	<u>100,000</u>	<u>100,000</u>

b) Aging at Home

The LHIN received one time funding of nil (2010 - \$300,000) for the Aging at Home project.

c) Aboriginal initiative

The LHIN received net funding of \$7,000 (2010 - \$30,000) related to the Aboriginal Planning initiative. Expenses incurred during the year are as follows:

	2011	2010
	\$	\$
Consulting services	-	28,526
Accommodation and administration	74	-
Supplies and other	53	1,474
	<u>127</u>	<u>30,000</u>

d) Vaughan Hospital study

The LHIN received one time funding of nil (2010 - \$215,000) for the Vaughan Hospital Study.

e) Emergency department (ED) lead project

The LHIN received funding of \$75,000 (2010 - \$75,000) related to the ED Lead project. ED Lead project expenses incurred during the year are as follows:

	2011	2010
	\$	\$
Salaries and benefits	-	15,000
Consulting services	54,000	60,000
	<u>54,000</u>	<u>75,000</u>

f) Diabetes strategy

The LHIN received one time funding of nil (2010 - \$25,000) to support service expansion for the diabetes strategy.

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Notes to the financial statements

March 31, 2011

10. (continued)

g) French Language Services

The LHIN received one time funding in 2010 of \$52,589 to support Francophone community engagement activities. \$11,958 had already been spent in fiscal year 2010 with the remaining balance spent in fiscal year 2011. Expenses incurred during the year are as follows:

	2011	2010
	\$	\$
Public relations	39,680	9,473
Accommodation and administration	951	
Consulting services	-	2,485
	40,631	11,958

h) French Language Health Services

The LHIN received funding of \$31,455 (2010 - \$Nil) to support the implementation of French Language Health Services. Expenses incurred during the year are as follows:

	2011	2010
	\$	\$
Salaries and benefits	17,695	-
Accommodation and administration	764	-
	18,459	-

i) Critical Care LHIN Lead

The LHIN received one time funding of \$75,000 (2010 - \$Nil) to support Critical Care LHIN Lead. Expenses incurred during the year are as follows:

	2011	2010
	\$	\$
Consulting services	72,750	-
	72,750	-

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Notes to the financial statements

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10. (continued)

j) E-health

The LHIN received funding of \$ 600,000 (2010 - \$600,000) from eHealth Ontario specifically related to the e-health projects. E-health expenses incurred during the year are as follows:

	2011	2010
	\$	\$
Salaries and benefits	272,591	484,929
Consulting services	-	55,761
Accommodation and administration	17,172	52,950
Supplies and other	4,327	6,360
	<u>294,090</u>	<u>600,000</u>

11. General and administrative expenses

The Statement of Operations presents the expenses by function. The following table classifies the general and administrative expenses by object:

	2011	2010
	\$	\$
Salaries and benefits	3,159,718	2,967,561
Occupancy	242,485	196,643
Shared services	409,523	375,000
Public relations	104,408	63,984
Consulting services	53,798	224,282
Supplies	43,871	56,601
Board expenses (see below)	142,069	190,032
Mail, courier and telecommunications	37,939	49,925
Other	94,666	146,091
	<u>4,288,477</u>	<u>4,270,119</u>

Board expenses included in general operating expenses above include per diem costs and other Board expenses as follows:

	2011 budget	2011	2010
	\$	\$	\$
Board Chair per diem expense	48,000	41,725	47,775
Other Board members per diem expense	79,000	47,445	78,750
Governance costs and travel	63,700	52,899	63,507
	<u>190,700</u>	<u>142,069</u>	<u>190,032</u>

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 23 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2011 was \$243,135 (2010 - \$228,911) for current service costs and is included as an expense in the Statement of Financial Operations. The last actuarial valuation was completed for the plan as of December 31, 2010. At that time, the plan was fully funded.

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Notes to the financial statements

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13. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

14. Comparative figures

Certain comparative numbers have been changed to conform to the current year presentation.

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